The Default Primer Nursing Home Medicaid Payment System in Washington State

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RCW 74.46.501, RCW 74.46.496 See http://search.leg.wa.gov/pub In the blue search box, type the RCW number, check the 'RCW and Dispositions' option box, and click 'Search'. Also, see WAC 3 88-96-738

A. What is 'default' in nursing home payment?

Default, as used in the Washington State Medicaid Payment System, is actually a 'default case.'

"Default case" in RCW 74.46.020 (14) means no initial assessment has been completed for a resident and transmitted to the department by the cut-off date, or an assessment is otherwise past due for the resident, under state and federal requirements.

Although some defaults can't be avoided (see #2 below), a default case presents the following problem: ADSA (Aging and Disability Services Administration) cannot assign a Resource Utilization Group (RUG) because of no Minimum Data Set (MDS) assessment for the time period in question.

RUG scores are important to nursing facilities because they are used to calculate a final case mix score, which determines the *direct care portion* of the facility Medicaid rate. Since Washington State Medicaid rates are by facility rather than by resident, default cases can have fiscal impact.

What are the 'default groups'? When a RUG score cannot be calculated, the resident is assigned one of two "default" groups, BC1 or SSB.

1. **BC1 (1.0)** An initial/scheduled assessment or discharge is untimely or not completed. The lowest score of 1.0 is assigned as if the resident needed only very light nursing care.

2. **SSB (2.269)** The RUG score is calculated at a higher level (2.269 as of July 2007). ***SSB is high because residents who expire or go to the hospital most likely would have grouped into a high RUG classification.*** SSB is assigned when a resident:

a. Expires prior to completion of an initial 14-day assessment; or

b. Does not have an initial MDS completed; is discharged to an acute care hospital prior to completion of an initial 14-day assessment (AA8a=1); and does not return during the quarter.

Note: If a resident discharges to the hospital without an initial MDS completed but returns and stays long enough for a completed initial assessment, the RUG determined from that assessment is applied to the first stay (or stays if more than one) rather than the default of SSB.

How many default cases does it take to affect the nursing home rate?

It is possible that even one default may affect the final case mix score, which, in turn, may affect the facility rate. All records transmitted (for any payment source of Medicare, Medicaid, or private pay) are, to some extent, factored into the Medicaid rate. A complex weighted average is mathematically derived based on a number of factors such as the size of the facility, RUG group, the length of stay for a particular resident, location, and the total number of residents.

How is a case mix rate determined?
Washington State case mix is determined using two indexes along with allowable costs to establish the **direct care** Medicaid rate:

1. Medicaid Average Case mix Index (MACI) which is **with defaults** – This index is used to set the rate each quarter and includes 1) all Medicaid days and rug weights and 2) all defaults, regardless of funding source. Rates are affected by the MACI results of two (2) quarters back. E*xample: the July rate used January/March MACI and the October rate used April/June MACI.*

2. Facility Average Case mix Index (FACI) which is **without defaults** - This index is used only when rebasing (see item 3) to calculate the cost per case mix unit. The FACI used in a rebase is a weighted average calculation, using all 4 quarters of a designated year. The FACI uses all payer types, e.g., Medicaid, Medicare, private, etc.

NOTE: The July 2007 through current nursing home rates use the weighted average FACI for the 4 quarters of 2005 because the 2005 cost report is used for the current direct care rate component.

3. The term "rebasing*" refers to the following department definition: **Rebased rate** or **cost-rebased rate** means a facility-specific component rate assigned to a nursing home for a particular rate period established on desk-reviewed, adjusted costs reported for that facility covering at least six months of a prior calendar year. That year is designated to be used for cost-rebasing payment rate allocations under the provisions of chapter 74.46.

4. How the rate calculation works - The direct care rebase allocation (3 above) which uses the adjusted allowable cost is divided by the four quarter FACI (2 above). This is now called the 'cost per case mix unit.' The cost per case mix unit is then compared to the facility's Peer Group Median cost per case mix unit. If the facility's cost per case mix unit is greater than the Peer Group Median cost per case mix unit, the facility's cost per case mix unit will now be the Peer Group Median cost per case mix unit. However, if the facility's cost per case mix unit is equal to or less than the Peer Group Median, the facility will keep its own cost per case mix unit. Finally the resulting cost per case mix unit is multiplied by the MACI (1 above) to determine the direct

care payment rate allocation. The direct care payment rate allocation is calculated on a quarterly basis using this methodology. On a facility specific basis, the higher the MACI, the higher the rate. In general, reducing defaults is a good way to increase the MACI.

What kinds of assessments are used for rate setting?
Any transmitted assessment based on any funding source and of any type (from the short Medicare Prospective Payment System Assessment Form (MPAF) to a full MDS assessment), is considered an assessment in Medicaid rate setting.

With **Facility Average Case MixIndex**, ADSA looks at all transmitted assessments, EXCEPT those in default.

With **Medicaid Average Case MixIndex**, ADSA considers ALL assessments to see:

If the assessment is a Medicaid assessment; or

If any assessment is in default. If either or both criteria apply, the assessment is included in the calculations.

Assessments are counted based on: 1) The R2b signature date; 2) If a transmitted record is not a discharge (reason 6, 7, or 8) or a reentry (reason 9). Example: If the record is not coded 6, 7, 8, or 9, it is considered a completed assessment on the R2b date for Washington State Medicaid rate setting.

Does the use of the short assessment, MPAF, create defaults for the State of Washington Case Mix?

The Medicare Prospective Payment System Assessment Form (MPAF) is a customized version of the Minimum Data Set developed to minimize facility data collection requirements. The MPAF, when used in the correct circumstances and along with any required discharge tracking forms, does not create defaults.

In Washington State, Medicare residents may receive a MPAF for required Medicare Skilled Nursing Facility (SNF) PPS assessments at days 5, 14, 30, 60 and 90 of Medicare Part A covered stays and these are all included on the quarterly case mix report along with their corresponding RUG score. It may also be used to meet the requirement for 'Other Medicare Required Assessment' (OMRA) 8 to 10 days after cessation of all rehabilitation therapy.

Did you know? If a full assessment is completed for a resident in a Medicare bed or in a licensed only bed (assuming that the resident does not additionally need assessment for any other reason), the data sent that is in addition to the MPAF data is *not stored* because CMS does not allow states to retain the data or forward it to the federal repository.

How much time elapses, after MDS transmittal, before a nursing home knows of any default scores and other resident RUG scores?

A facility does not know the quarterly RUG scores until ADSA Rates produces the Final RUG report. They should, however, review their Validation Reports and other reports for errors that give indications of errors and problems that will result in defaults. A preliminary RUG report is posted each quarter as a courtesy to facilities and to give a last chance for error corrections.

Later the final RUG report is produced and posted on the MDS Submission website. State law only requires a final quarterly RUG report.

Schedule:

1st quarter runs 1/1 through 3/31. The preliminary RUG is run 4/16 and posted three days later, around the 1/19. The final RUG cutoff date is one month and one day after the end of the quarter. Assessments received on or after 5/2 are not considered on the Final RUG.

2nd quarter runs 4/1 through 6/30. The preliminary RUG report will be run 7/16 and posted around 7/19. The final RUG cutoff date is one month and one day after the end of the quarter. Any assessments received on or after 8/2 will not be considered on the Final RUG.

3rd quarter runs from 7/1 to 9/30. The preliminary RUG report will be run 10/16 and posted around 10/19. The final RUG cutoff date is one month and one day after the end of the quarter. Any assessments received on or after 11/2 will not be considered on the Final RUG.

4th quarter runs 10/1 through 12/31. The preliminary RUG report will be run 1/16 and posted around 1/19. The final RUG cutoff date is one month and one day after the end of the quarter. This means that any assessments received on or after 2/2 will not be considered on the Final RUG.

Note: If the Cut-off date falls on a weekend or Holiday, the next business day will be the final cut-off.

E. Should all defaults be avoided?

Not *all* defaults should be avoided. Contrary to popular opinion, default is NOT always synonymous with 'lowest possible payment' and ADSA does not give prizes to the facilities with the lowest default rate! J Although ADSA does review all defaults to provide information to nursing facilities; some defaults are no-fault defaults that result in higher scores than the actual completed assessment. Here is an example: *Mr. XYZ enters a NF under Medicaid on May 1st. On May 2nd he exits the facility to an acute care hospital and does not return to the facility during the quarter, based on an acute condition. The MDS nurse is required by her administration to complete a MDS assessment based on only that short observation period in the facility. She completes an assessment and later compares the RUG score from that assessment to the SSB* default score, only to discover that the RUG score would have been higher had she taken the default SSB* instead of the actual MDS score.*

The above scenario is not uncommon and also occurs when a resident expires. It is not reasonable to implement a "no default" policy. With a "no default" policy, staff complete assessments on all residents even if they are in the facility only a few hours. Please consider the following issues:

1. In the case of an initial 14-day assessment: When a resident has deceased, there is absolutely no clinical value to the facility completing the MDS after the resident has died in that it will not benefit the resident in terms of an assessment and care planning tool, which is the primary reason for the MDS.

2. It takes several hours to complete an MDS, so the facility needs to consider from a cost-benefit standpoint if it is worth the time of their staff to complete a non-required, non-beneficial assessment in order to avoid the label of "default".

3. The SSB* default is established at a relatively high level because residents who expire or go to the hospital within the first 14 days of their initial stay would most likely receive a higher RUG Score had they remained long enough to have an assessment completed. As a result, a completed assessment for some residents may result in a RUG group lower than the SSB* default. WAC 388-96-738

In summary: When the task of completing an assessment consumes staff time and energy, is of no value to the resident, may have an adverse fiscal impact on the rate, and is not required by State or Federal regulation - why complete it?

F. What about Medicare Payments?

The federal agency of Centers for Medicare and Medicaid Services (CMS) oversee payment of Medicare SNF services through the Prospective Payment System (PPS). PPS payment rates are adjusted for case mix and geographic variation in wages and cover all costs of furnishing covered SNF services. Medicare payments are issued at the federal default level if no MDS is on record for the covered time period. Also, missing Medicare assessments can impact the Washington State case mix indexes and ultimately the Medicaid rate. Medicare requires only the short MPAF, not a full assessment. *Example:* A resident in a Medicare Part A nursing home stay is a "short stay" that expires or is discharged to an acute care hospital. The facility needs to complete a MDS for a RUG score to avoid default when billing Medicare. In this case the facility should consider completing only a Medicare assessment (A8a = 0, A8b = 1) and using the MPAF rather than a combined OBRA/Medicare Assessment (A8a = 1, A8b = 1). This practice saves staff time.

What reports, other than the RUG report, can help prevent defaults?

The Final Validation Report is the most important tool available to help you avoid default cases. Additionally, several other online reports posted in the same list each month can give you clues of potential problems. Look on the web site where you upload MDS data for these reports:

Final Validation Report (6-digit number with 'f' as the extension: Example: 123456.f) Regularly review the Final Validation Report warnings/errors. These are system messages regarding items that could result in defaults. If you are perplexed by a message, please investigate and, if need be, contact ADSA or the IFMC Help Line. On occasion some problems can be tracked to an issue with a specific software vendor, so you may need to contact the MDS vendor. Please don't dismiss error messages or inconsistencies with, *'Oh, the system makes mistakes…'*. The software is very accurate , but the complexity of the data sometimes results in problems that are hard to unravel.

MDS Questionable New Resident Report (QR*.txt) A list of residents showing up as apparently new based on a MDS record that should *not* be the initial record for a new resident. (*Example: The system receives a quarterly review on an apparently new resident.)* When resident identifiers (name, SSN, birth date, or gender) contain one or more typos, the State MDS

System may have incorrectly identified an existing resident as new. To correct, use the 'MDS Correction Request'.

MDS Residents With Changes to Resident Identifiers (CR*.txt) A list of any residents with resident identifiers that you have changed. Check to be sure that residents listed are not really new residents incorrectly matched with an existing resident. If the resident **is** new or if any identifiers are incorrect on either the new or prior record, fix with the 'MDS Correction Request'.

MDS Missing Assessment Report (MR*.txt) A list of assessments missing in the system. If these records are known to have been transmitted, perhaps they were sent in 'Test' mode only.

End of Month Roster Report for MM/YYYY (RR*.txt) Do you see listed any residents who have actually left the facility? If so, perhaps their final assessment was not coded as a discharge.

MDS New Admission Report (AD*.txt) Does this list compare with your records? If not, why not?

Residents Discharged Without Return for MM/YYYY (DR*.txt) Check this list with what actually happened in your facility.

MDS Activity Report/Report Period MM/YYYY (AR*.txt) Inclusive list of all activity in the month.

The 10 Most Common Reasons for NH Payment Default

1. **TEST Mode** An MDS assessment has not been submitted, but actually was completed and transmitted. This happens when the TEST Mode **rather than** Production Mode is mistakenly utilized. The assessment was *not* actually submitted, though the facility thought it was. CMS has asked that facilities not use TEST mode to routinely check data.
2. **Initial Assessment Not Timely** A facility fails to complete an initial assessment in a timely manner. *Example: A Medicaid resident was admitted to a nursing home and an initial assessment is not completed on or before day 14. The resident remains in the facility.* An assessment completed on or after day 15 will result in a BC1** default.
3. **Scheduled Assessment Not Timely** When a facility fails to complete a scheduled quarterly assessment in a timely manner, a BC1 default occurs. *Example: A Medicaid resident in a nursing home has had an initial OBRA assessment completed. The resident remains in the facility and the first quarterly review is due and completed late, resulting in a default grouping of BC1**.* A default occurs where no assessment is completed by the end of 3 months plus the 5-day grace period. The default is calculated back to the due date of the new assessment. The date used for measurement is the signature date showing completion for MDS (R2b).
4. **Lacking Assessment At Discharge**

   Scenario #1 – Discharge With No Assessment Ever When a resident is discharged with no assessment completed on or before the 14 th day (the date of entry plus 13 additional days) a default occurs**.** The Discharge Status disposition in field R3 determines the default:

- **BC1** - Discharge status codes **1, 2, 3, 4, 6, 7,** or **9** give a BC1** default.
- **SSB** - Discharge status code **5** (**Acute care hospital**) or **8** (**Deceased**) gives a SSB* default except in the circumstance of status code 5 followed by a return to the nursing home during the quarter.

Scenario #2 – Discharge With Assessment Due *When a resident has had at least one assessment completed and then is discharged with a discharge status code of 5 (Acute care hospital) or 8 (Deceased) at the time another assessment is due, a default occurs. Timing determines the default:*

- ***BC1*** *– Discharged to the hospital or deceased after the current assessment expires but during the 5-day grace period.*
- ***SSB*** *– Discharged to the hospital or deceased after not only the current assessment expires, but also beyond the 5-day grace period. The exception to this rule occurs when status code 5 is followed by a return to the nursing home during the quarter.*

5. **No Background Face Sheet Info** A default occurs when a facility **does not use code '8' in AA8A**, 'Reason For Assessment' on the Discharge Tracking Form, after a resident leaves the facility before 14 days without an Initial Assessment. (14 days equal the day of entry plus 13 additional days.) Code '8' means 'Discharged prior to completing initial assessment' and **is the only discharge tracking code that sends the Background Face Sheet Information.** The Background Face Sheet contains the date of original entry. Without code '8', the stay information cannot be accurately determined because no entry date exists and the stay is based solely on the discharge date.

6. **Resident Wrongly Identified** Through data input error in one or more of the fields related to the resident identification (Name, DOB, SSN, Gender), a new Resident ID is erroneously created and, as a result, an individual has more than one Resident ID. This causes default since each Resident ID contains only part of the assessment data. A default of 'BC1'** will eventually appear for one or both of the Resident ID's.

7. **Discharge Not Coded As Discharge** A resident's final assessment must be coded as a discharge so that a Discharge Tracking Form is processed or the system will show that resident in the facility but without continuing assessments, eventually causing a BC1 default. This default continues as long as there is no assessment to cover the resident's stay *and* no discharge tracking form submitted.
   The Discharge Tracking Form has 3 options for A8a:
   6. Discharge-return not anticipated,
   7. Discharge-return anticipated, and
   8. Discharged prior to completing initial assessment.

8. **Data Entry Error in Date Field** When one or more dates are entered incorrectly, the following problems can occur:
   a. An incorrect **R2b date** (date that the RN assessment coordinator signed as complete) can result in late assessments which default;
   b. At the time of discharge, an erroneous **entry date/reentry date** can cause defaults because assessments are then calculated with incorrect dates. (The stay period that

was started with the admission tracking form was never closed even though a discharge tracking form was successfully submitted). *Example: A resident is discharged with the wrong date entered in the field titled 'most recent date of entry/re-entry'*. This error can eventually result in a default of BC1**.

9. **Data Entry Error In AA8A & AA8B** When a MDS assessment is transmitted with a data entry error in the 'Reason For Assessment' (AA8A and AA8B). Subsequent assessments will not make sense. *Note:* If the reason for assessment is entered erroneously, inactivate the assessment and then complete another. A8a and A8b, are the only items that can't be corrected with 'Modification of Assessment'.

10. ***Did I say 10? We could only come up with 9.***

Default Types

The Default types used above are defined in **WAC 388-96-738**. Defaults in Washington State are codes used when a resident cannot be 'grouped'. ADSA cannot assign a resident to a Resource Utilization Group (RUG) because no MDS measurement is available for that time period.

*** "SSB"** is assigned when a resident 1) dies before an initial assessment is completed; or 2) is discharged to an acute care facility before an Initial Assessment is completed and the discharge tracker is coded correctly. SSB has a RUG weight of **2.269**. SSB is a no-fault default; in that it is unavoidable. The SSB score may actually **exceed** that of a completed MDS assessment. **WAC 388-96-738** defines SSB as 'the special care case mix group'.

**** "BC1"** is assigned when SSB (above) does NOT apply AND when no assessment or an untimely assessment has occurred. BC1 is the lowest RUG weight at 1.00.

Nursing Home Rates / MDS / Clinical Contact Information

NH Rates/MDS/Clinical Contact Information		
Toll free Help:	ADSA Help Line: 800 818-4024	Federal Help Line: 888 477-7876
NH Rate Questions:	Bobbie Howard 360 725-2474	Allen Miller 360 725-2475
MDS / Clinical Questions :	RAI Coordinator Marjorie Ray 360 725-2487	MDS Automation Coordinator Shirley Stirling 360 725-2620